



STATE OF HAWAII
DEPARTMENT OF HEALTH
4348 Waiālae Avenue, #648
Honolulu, Hawaii 96816



APPLICATION # _____

Medical Use of Marijuana Caregiver Certification

SECTION D. *This section to be signed by the primary caregiver, if one is designated*

Applicant's Name:

Last

First

Middle

Caregiver's Name:

Last

First

Middle

Note: Please use your name EXACTLY as it appears on your VALID government identification

CAREGIVER STATEMENT OF UNDERSTANDING AND CERTIFICATION

I CERTIFY that :

- ☐ Yes ☐ No
- 1) I have read and understand part IX, chapter 329, HRS: Medical Use of Marijuana;
 - 2) I agree to undertake responsibility for managing the well-being of the qualifying patient, so named as the applicant on this application, with respect to the medical use of marijuana;
 - 3) I agree to abide by the Conditions of Use as outlined in part IX, chapter 329, HRS, as well as ALL other applicable sections of this law; and
 - 4) I understand that in accordance with part IX, chapter 329, HRS, medical marijuana can only be grown at one location, as designated in Section E of this application.

Under penalty of perjury, I attest that all information submitted is true to the best of my understanding and that I have not intentionally furnished false or fraudulent information or omitted any information from this application. By signing this document I acknowledge that I am subject to part IX, chapter 329, HRS, and all other applicable laws for the medical use of marijuana in the State of Hawaii. I understand that even though I am following Hawaii state laws regarding primary caregivers of medical marijuana patients, I may not be protected against arrest, prosecution, or conviction under Federal law.

CAREGIVER'S SIGNATURE

DATE